

ANNUAL REPORT

2021 - 2022



Comox Valley Hospice Society
2900 Cliffe Avenue
Courtenay, BC V9N 0J1

A YEAR IN REVIEW



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MESSAGE FROM THE PRESIDENT

In May 2021 the board of the CVHS completed a several month process of developing a strategic plan to take us through the next several years (this plan is included in this Annual Report). Although the concepts are broad, they are meant to “bring us home” to our core values and act as guideposts for living out our foundational purpose: TO EASE THE JOURNEY OF DYING AND GRIEVING.

With well-deserved retirements for some of our staff, there has been restructuring of duties and fresh faces in the office. COVID has continued to test us, but we have risen to that challenge! Staff and volunteers have found creative ways to engage with our clients, demonstrating flexibility and innovation. Jane Sterk, our executive director, has provided a steady hand and diligently invested her energy to ensure we are successful in our modified delivery of services and in finding ways to fund our work. Speaking of funds – The Phantom Ball and the Cylepath team again exceeded the goals they set for themselves!

In the midst of all this, the superheroes I call staff and volunteers were ALSO preparing for the move to our new home at the Aitken Community Hospice – the culmination of many years of work and dreams. We opened the doors in July 2022! A hearty thanks to our sponsors, donors, Golden Life Management, and the Palliative Team at Island Health for helping this become reality.

There are not enough THANK YOU’s in the world to express the gratitude of myself and the board for everyone’s contributions to the Comox Valley Hospice Society. You have proven this society to be not only compassionate, but also resilient. BRAVO!

Joan Gillies
President Comox Valley Hospice Society

Board of Directors

Joan Gillies - President
Lisa Murphy - Vice President
Debi Sargent - Secretary
Carol Baert - Treasurer
Raida Bolton - Director
Joan Collinge - Director
Karen Guinan - Director
Patricia Korven - Director
Tracey Lawrence - Director
Karen McKinnon - Director
Sasha Nowicki - Director
Sue McKeeman – Volunteer Recording Secretary

Staff 2021/22

Administration

Jane Sterk - Executive Director
Monique Thompson - Office Manager

Program Coordinators

Christy Linder (Retired)
Tara Zyla (Maternity Leave)
Tina Manuch (Maternity Leave Replacement)

Palliative Counsellors

Ruth Barry (Retired)
Angela Hope
Kasia Stepan
Corrie Howard

Bereavement Counsellors

Brenda Stanton (Retired)
Tamara Tkachenko

Volunteer Coordinator

Camilla Moul

Program Assistant

Joanne McKay

Communications

Judy Wing



STRATEGIC PLAN - MAY 2021

We Believe in...

- Compassionate person-centered care and support
- Respect for personal autonomy and choice
- Teamwork and community collaboration
- The value of our volunteers
- Relationships grounded in honesty, integrity, and trust
- Thoughtful stewardship of all financial resources

Our Purpose is...

Easing the journey of dying and grieving.

We Are...

A community supported, self-sustaining organization that models excellence.

Our Strategic Objectives

- Financial: Ensure our financial planning builds clarity, confidence, and long-term sustainability.
- Programs: Ensure our programs are comprehensive, inclusive, relevant, and equitable.
- Process: Create a multi-year, "fit for purpose" marketing and donor engagement strategy.
- People: 1) Develop succession planning for all critical positions.
2) Ensure high quality employee and volunteer recruitment, training, and support programs

FINANCIAL UPDATE

The Comox Valley Hospice Society (CVHS) ended the fiscal year in a good position. With the exception of income from grants, all revenue line items were at or ahead of budget. Most are higher than the prior year. Of particular note is donations that were \$200K ahead of budget due to a large bequest.

Overall, expenses were approximately 4% over budget with most of the variance related to the decision to purchase some items in advance of the move to the new facility in June.

Financial Sustainability

In the CVHS strategic plan, the board set a goal to ensure our financial planning builds clarity, confidence, and long-term sustainability. For a small non-profit like CVHS, financial sustainability is an ongoing challenge. Other than a small grant from Island Health (IH), CVHS has no core funding so we are dependent on grants, donations, bequests and event and other fundraising, none of which is guaranteed.

It is an unfortunate statement about what society values that non-profits must rely on philanthropy for their survival.

The focus in the year ending March 31, 2022 has been twofold: having sufficient income to meet our budget; and, developing strategies that simulate core funding and have the potential for increasing revenues.

Revenue to Meet our 2020-21 Budget

In addition to the annual grant from IH, we were successful in getting grants from the Province of BC (Community Gaming Grant); the Comox Valley Community Foundation (rent relief); United Way BC (volunteer engagement); and, the Sovereign Order of St. John (Grief App development). We also continued to receive money from the federal government through the Canada Emergency Wage Subsidy (CEWS) until that program ended.



FINANCIAL UPDATE CONT...

In the fiscal year ending March 31, 2021, we were unable to conduct the Ultimate Fifty-50 fundraiser that CVHS had been hosting since 2014. After some consideration, we elected to retire permanently this event. Gaming events are administratively intensive requiring lots of volunteers and complex scheduling. The perceived value of the Ultimate Fifty-50 was being visible in the community and getting new donors. An analysis of ticket purchasers showed that few became donors or participated in other events.

We focussed on two major events: the Phantom Ball Stay-at-Home Gala and the Cycle of Life Tour (COLT), a decision that resulted in a significant increase in revenue to both events. The Cyclepaths COLT 2021 team raised \$50,000, compared to \$40,000 in 2019. Phantom Ball 2021 generated \$67,000, \$6,000 more than 2020.

The committees that planned and executed both events were amazing. Special mention goes to board members Raida Bolton and Debi Sargent, who both ride for the Cyclepaths, and to Tracey Lawrence and former board member Chris Swift. Super volunteer Sue McKeeman and staff members Monique Thompson and Jane Sterk rounded out the Phantom team and Jane and Judy Wing provided staff support for the COLT fundraiser. Donations and bequests brought in the remaining income.

Strategies for Long-term Ongoing Revenue

Our first initiative aimed at increasing revenue was to adopt a new donor management system to ensure people have a positive experience when they donate to CVHS. We switched to Keela Nonprofit Software, a platform developed in Vancouver and hosted in Canada.

In the spring of 2021, we subscribed to WillPower, an initiative of the Canadian Association of Gift Planners whose goal is to encourage more Canadians to leave money to charities in their wills. While the return on this investment was not sufficient to continue, it helped the Society focus on

planned giving, an important source of long-term income. On our website, we added interviews with three donors who are leaving us bequests. Thanks to board member Sasha Nowicki, a helpful Leave a Legacy Information Sheet is on our website.

We are set up to receive donations of securities through our Canada Helps Account. Recently, a donor made CVHS a beneficiary on their Tax-Free Savings Account (TFSA). CVHS can named as a beneficiary on insurance policies, mutual funds, annuities, registered pension plans and registered accounts like an RRSP or Registered Retirement Income Fund (RRIF). Canada provides favourable tax benefits for charitable donations.

This year, the board set up the Comox Valley Hospice Society Fund at the Comox Valley Community Foundation. This fund will provide an annual return in perpetuity and so it becomes core funding. The current fund sits at just over \$300,000. The goal is to grow the fund to \$10 million over the next decade, which would provide an annual income of around \$350,000. The Community Foundation generously agreed to continue providing CVHS with annual income from Catherine Mary Aitken & Elizabeth Cherry Aitken Fund.

Finally, we increased our presence in the Comox Valley Record and on social media.

Beyond Getting By

The Comox Valley needs more of what CVHS offers. Historically, we have focused on doing only what we can afford to do. To grow to meet even a small portion of the unmet need is a whole other dilemma. We are turning away two requests per day for bereavement support. We need another Bereavement Counsellor.

Everyday our Palliative Counsellors have to prioritize whom they can see. Over the course of a week, they try to fit everyone in, but it is a challenging juggling act. We need additional palliative counselling.



FINANCIAL UPDATE CONT...

And, as important as adding additional service hours is addressing the wage disparity between our staff and people in similar positions in the health and social services sectors. Improving wages is a top priority for the Society. Our staff members are highly educated and skilled and they do this work at an income below what they could get elsewhere because working in hospice palliative care is life affirming, transformative and meaningful. Over time, we want to reflect their value in our wages and that takes new money.

OUR VOLUNTEERS

Submitted by Camilla Moul, Volunteer Coordinator

The past year brought much change, growth and opportunity! I became the Volunteer Coordinator in February 2022 just as we started our first 30 hour/10 week Basic Palliative Volunteer Training since 2019.

We conducted the first eight weeks of training via Zoom and met in person for the final two. I was initially concerned about conducting the majority of the training over Zoom but the participants formed connections quickly. We had ten new volunteers graduate in early April. As part of their orientation, each new volunteer did a buddy shift at both Comox Valley Hospital and the Hospice at The Views (HaTV). The feedback from the volunteers was very positive and many are now planning to join our hospital and Hospice visiting teams.

Each volunteer brings a unique skill set to the organization. One of our new volunteers is completing their Masters in Counselling, another is completing a degree in metaphysical studies and we have a retired counsellor, three former nurses, a yoga teacher and a yoga therapist!

One volunteer has previous experience volunteering with a hospice in the interior of BC and she expressed gratitude that our training is so heart centered.

The training she completed with her previous organization was more focused on the practical aspects, not the psychosocial elements. She really appreciated the content and tone of the training she received with CVHS.

Early in 2022, we also offered our first men's only peer led grief support group. This group was developed by a group of four male volunteers using Alan Wolfelt's ***Understanding Your Grief Support Group Guide***. The volunteers did a wonderful job of developing and curating thoughtful and relevant content for this purpose-made group. We are very proud of the work they did.

We are looking forward to the upcoming year. Our new volunteers with yoga experience have already expressed interest in developing a new grief yoga program for us to offer in the fall. We have several recent volunteer graduates who are also interested in joining our Advance Care Planning team. We are eager to restart programs that were previously suspended due to COVID and seeing what other groups we may be able to offer our clients. We are so excited to see how the talents and skills of our volunteers can enhance the services we provide in the community. I am looking forward to working with them to ensure they are in roles that complement their natural skill sets and give them meaningful volunteer experiences.



Class of 2022



Volunteer And Mentor Celebrates 20 Years of Service



Ken O.

An Excerpt - Poetry at the End of Life Frank Osteski

Don't just stand there with your hair turning grey
Soon enough the seas will sink your little island
So while there is still the illusion of time
Set out for some other shore.
No sense packing a bag
You won't be able to lift it into your boat
Give away all your collections
Take only new seeds and an old stick
Send out some prayers on the wind before you sail
Don't be afraid.
Someone knows you're coming
An extra fish has been salted.

Volunteer Story

Just bursting to share that I had a wonderful, beautiful first shift alongside the ever-lovely and experienced Ken O. at Comox Valley Hospital today. What a joy to tag along with him for 2.5 hours, meeting various folks and having chummy bedside chats. Two particular moments that stood out for me were witnessing the smiley pleasure of a patient licking the paper lid of his dixie ice cream cup, the only thing he reached for on his lunch tray. Another moving experience involved holding both hands of a precious lady with my left hand whilst laying my other hand on her brow as she guided me to do ... and watching her melt with the comfort of that simple, warm healing touch.

Ken showed me where the hospice books are kept, how to enter a room, how to greet a person and check if they'd like a visit that day; he brilliantly demonstrated the patience, kindness and deeply caring heart required for this work. Those who recognized Ken from previous visits did so enthusiastically, and without fail asked when he would be back. I now appreciate how meaningful these visits are to folks in hospice care!

I was touched to the core when, at the last bedside of our visit, Ken asked the lady two questions: "Do you like her? And should we keep her?" in joking reference to me, the rookie. I was deeply moved by their kind welcome of me and want to applaud Ken's mentoring techniques. He let me find the books and enter notes, and he went in search of persons in their rooms which was a very helpful way for me to get to know how the palliative wards are laid out. The best way to learn is certainly by doing, and he allowed me to jump right in. I felt completely "in the zone" and privileged to commence this heart work. I admire Ken for all he does, and for how he does it: what a star! Today will stand in my memory the rest of my days.

Janet H.



CLIENT SUMMARY

Client Category Definitions:

Anticipatory Grief Clients: refers to palliative clients and/or the family members or loved ones of a CVHS palliative client who receive CVHS support, including but is not specific to: brief respite, anticipatory grief counselling, volunteer support, caregiver groups, Self Care Clinic, Healing Meditation, etc.

Palliative Clients: refers to individuals who have received a palliative diagnosis or are at the end stage of life and/or end stage of a life-limiting, ultimately life-ending chronic illness.

Bereavement Clients: refers to family members/loved ones of CVHS palliative clients who have died recently (usually within the past year). Due to limited resources, we are unable to support individuals grieving the death of a loved one that was not a CVHS palliative client. Nor do we have the capacity to assist those dealing with chronic bereavement – deaths that occurred several years or even decades ago or to support an individual with multiple complex mental health issues where bereavement is one aspect.

Outreach Clients: reported as of 2021, includes individuals who do not fit in any of our traditional categories. However, they are people we feel may still be in need of some of our services i.e. a frail bereaved individual who no longer fits the parameters for bereavement, who has significant health issues but is not yet deemed palliative. We placed some individuals in this category during the COVID period that we would normally discharge from services but because of frailty, isolation or limited community resources, we continued to follow through the pandemic.

Clients Served

April 1, 2021 – March 31, 2022

Clients Served

- Total Client Profiles Open During the Year (of which 791 were individuals)872
- Total Clients Active During Period (of which 655 were individuals)..... 721
- Total Palliative Families.....271

Clients by Service

- Bereavement Program 453
- Palliative Program 270
- Anticipatory Grief and Caregiver Support 132
- One-time Support 16
- Outreach 1



BEREAVEMENT PROGRAM

As Comox Valley Hospice Society (CVHS) feared, COVID19 and the restrictions associated with the pandemic left our community with a tsunami of grief. In addition to an increase in the number of clients requesting grief support, we saw an increase in the percentage of bereavement clients experiencing complicated, prolonged, and chronic grief. What used to be less common became more typical and clients require more time and resources to navigate through their grief.

Between April 2021 and February 2022, our waitlist for grief support services grew from a manageable two-week wait period for follow-up with a counsellor to over 6 months. While our staff attempted to accommodate the increased demand and complexity within our available resources, this proved to be impossible. The breadth of services CVHS has been able to offer to the community in the past is no longer sustainable. In March, we made the heartbreaking decision to limit our self-referrals and revise eligibility requirements.



We continue our commitment to provide compassionate care within our capacity. Our revised referral criteria for CVHS Bereavement Services are for those:

- *Who have experienced a recent bereavement (within the past 12 months)*
- *Who have received Anticipatory Grief support through CVHS (with the last session within the past 12 months)*
- *Whose loved one received palliative support through CVHS (last session was within the past 12 months)*
- *Who have been referred from the Palliative Home and Community Care team*

Those **no longer eligible** for our bereavement services include:

- *Those with historic bereavement (beyond 12 months)*
- *Self-referrals from someone that has not had any past contact with CVHS for themselves or their deceased loved one*
- *Third party referrals including: a referral from a family member, a friend or a community agency such as Mental Health*
- *Unanticipated/sudden loss where the individual was not previously connected with CVHS*
- *Someone with a diagnosis of dementia (out of our scope of practice)*
- *Folks whose grief is compounded by mental health concerns or addictions*

While these changes have provided more timely support for those eligible for service and less stress for our staff, we are looking for new sources of funding to hire an additional bereavement counsellor. One solution might be a benefactor who would be willing to provide multi-year funding of \$65,000 to \$75,000 per year for a minimum of 5 years. We are also exploring grant funding but grants of this size are rare and multi-year grants are uncommon. Over time, as we are able to increase our revenue, we will re-evaluate our bereavement program.



BEREAVEMENT CLIENT

STORY

A Client's Thoughts on CVHS

When I was thirty the person that I loved and trusted the most in this world left me without any warning or time to prepare. I wasn't left with just heartbreak and longing, I was leftover in a world that no longer made sense to me anymore and sensations in my body that were foreign, involuntary and happening without my consent.

Before my beloved died, I'd never experienced a loss that changed my life so dramatically. From my spiritual beliefs and to my worldview right down to not knowing what possessive pronouns to use, I was left bewildered. Was it still our bed if I would be the only one sleeping in it now?

In the world I was familiar with, people died when they were old, if you were a good person then good things happened to you. I longed for my future because I thought we, me and my beloved – the person that I chose to spend my life with – were in control of it. But my beloved's death changed all of that.

My beloved's death changed the axis of the planet. It made all the lights too bright and the pace of walking too quick. It exposed all of my emotional vulnerabilities without leaving me any tools to protect myself. I was barren.

In quiet moments, my brain was unrelenting. Did I deserve this? Was my beloved's death some sort of lesson I was supposed to learn or a consequence for something that I'd done? If being a good person and doing the right thing doesn't offer any protection from dying young, and at random, what agency do I have over my life at all? Do my in-laws hate me? How long is this pain going to last? What's the point of sticking around in this life if the only outcome for all of us is death?

Physically, when my beloved died an energy was born in my body. A dynamic space created by conflict between what was, what is, what was supposed to be and knowing enough to compare all three. It manifested in brain fog, memory lapses, fatigue, anxiety, changes to my appetite, irritability, extreme introversion, weight gain, insomnia, immeasurable rage, excruciatingly low energy, and debilitating loneliness.

And then COVID-19 happened. I needed more help. I went to the CV Hospice Society for counselling. I don't have a rosy comeback story about my experience with counselling from the CV Hospice Society. Counselling did not cure me of my grief. Although it's helpful, counselling is not that powerful. Nothing is. I do not have a rosy comeback story about my experience with counselling but I have this: I am still here. I am still alive.

Since my beloved died there are very few things that have offered me refuge from the turbulent waters of grief. Counselling has been one of them.

My counsellor is the only person who listens without an agenda, without any knowledge of who I was before and only acceptance for the person I am in that moment on the day that we speak.

My counsellor doesn't care if I change my mind or I never return to the person who I was before my world was shattered. They care if I've eaten that day and drank a glass of water. They care if I'm okay enough to make it to the next day, and then the day after that one.

My counsellor will return to the anxieties that play on repeat in my head over and over again, even if we talked about them last week and the week before that. The patience of a counsellor is unparalleled. The boundaries of their acceptance are limitless.



BEREAVEMENT CLIENT STORY CONTINUED

A Client's Thoughts on CVHS Continued...

My counsellor understands how significant it is when I set boundaries to protect my own mental health. They celebrate my wins with me no matter their size. And when the trajectory of my post-traumatic growth dips into the negative space again they are still there. Still by my side. Still on my team. Without judgement and without expectation.

Grief is unrelenting. It is vicious at times. It can be cruel. But it cannot be conquered, overcome, or resolved. So what power does anyone have to help? The best grief support anyone can offer is to make a bereaved life easier and more comfortable. That's how people like me learn how to live around the legacy of our beloveds.

Focusing on comfort and ease, that's the work that my counsellor does. It's not always obvious but I know it to be true.

Why? I am still here and I am still alive.



New Resources

Two apps are being developed for bereavement support, funded by a grant from Sovereign Order of St. John. One is based on our self-led Nature Walks program "**Strolls for Wellness**" program which provides themed nature walks and reflective questions to support emotional healing.

The second app, "**CVHS - A Year of Firsts**" was also under construction, supporting the expression of grief through writing prompts, affirmations, art activities, and inspirations arranged in categories of grief related emotions and experiences. The content of these apps can be viewed at:

comoxhospice.com/grief-resources



PALLIATIVE PROGRAM

Comox Valley Hospice Society palliative services take place at the Comox Valley Hospital (CVH), the community Hospice (formerly Hospice at The Views) and in the community. Our palliative counsellors work closely with Island Health's palliative team and the medical staff at the hospital to ensure care plans attend to the psychosocial and spiritual needs of palliative patients, caregivers and their circle of support.

Our counsellors follow-up new referrals and conduct assessments either over the phone or in-home visits. We assess clients for palliative and anticipatory grief services and then determine how to creatively meet the demand for support.

There was no interruption of our palliative services during the past year and we continue to provide high quality care in the Comox Valley. We focus on the most important things to consider when working with individuals and families at the end of life.

Some words that convey a palliative approach: compassion, individual focused, empathy, family oriented, wholehearted, hospitable, kind, comforting, a better way for end of life, respectful, privilege, trust, spiritual, holistic, openness, witness to grief, calm presence, rewarding.

When we asked our counsellors what they would like to share about their work with Hospice, there were many things said but they all referred back to the beautiful people with whom they felt honored to navigate life's end.

In the past year, amongst those who shared their end of life journey with us, there was ...

- The man who was known to have had *a pet chicken when he was a kid,*
- The lady who *liked her English tea at 1 pm everyday - and hot please!*
- The dad who *never got along with his brother but loved his sister,*
- The aunty that was *just like a mom,*
- The sister who became known for *making cookies for the whole neighborhood,*
- The one who as a teenager always *felt on the outs,*
- The uncle who *had the fast cars,*
- The one who *gave up drinking many years ago,*
- The grandma who *always wore that unique perfume,*
- The one who *lost the love of their life at age 30 and who was left to raise the children on their own,*
- The daughter who loved *gazing at the stars and felt a deep connection to nature,*
- The one who *did not want to take medicine,*
- The one who *made everyone laugh,*
- The professional who was a *community builder,*
- The one who was the *street bottle collector,*
- The young woman who *wanted her dog in her Hospice room,*
- The one who was *very afraid of cats,*
- The family who *grieved so loudly and the others who were very private,*
- The man who *wanted his wool blankets,*
- The one who *wanted their last breaths to be on their sailboat.*



Who are you?

At Hospice we get to know you. Our focus is to have individuals and families become known in their last days and our mission is to ease the journey of dying and grief. Thank you for making this possible.





PALLIATIVE CLIENT STORY

Told with permission by Palliative Counsellor Angela H.

I learned via the Palliative Care Nurses that a client of mine had been having a difficult few days with increased pain. I called the home wanting to offer support, being aware that this particular client's condition had been declining anyway. I offered to visit that afternoon and the wife indicated she would be most grateful. When I arrived, the wife burst into tears.

I found the patient in bed, in severe pain, also crying, and saying he just wanted MAiD (Medical Assistance in Dying). That he could not deal with this level of intense pain. I immediately sent a message to the Palliative Coordinator stating that this gentleman's pain remained uncontrolled. She called and suggested that the wife repeat the pain medication, which she did.

Half an hour later the pain still was not any better. I messaged the Palliative Coordinator again. She spoke with the wife asking her to give the pain medication a bit longer but did not seem to understand that the situation was critical.

I had noted that the wife was having a hard time truly describing her husband's condition and how the day had unfolded. I asked the wife to write down the whole chain of events, from the few days before when her husband was walking in the garden enjoying the lovely weather, right through to now when he was in so much pain he could barely move.

She had just finished writing out the full story when the Palliative Care physician called. With the story in front of her, she was able to describe the entire chain of events. The physician immediately assessed that this was an acute event, needed a trip to hospital for investigation as to the source of the pain, at which point she felt sure she could offer relief.

The patient did go to the hospital, still saying he just wanted MAiD. A CT Scan showed clearly the source of this sudden severe pain. The physician asked the gentleman to let her readjust his medications to see if she could help him. She said that she did not wish him to access MAiD while in such a crisis, or wish his wife left with the memory of his last days being so traumatic. The gentleman reluctantly agreed. Within 24 hours he was free of pain, walking without difficulty and wanting to go home.

I visited the couple this week. He remains free of pain, walking with a walker but with relative ease. He knows that MAiD remains an option but he is also now talking about Hospice being a possibility for his final days once he becomes too weak to walk.

Meanwhile he and his wife are so grateful for the extra time they have been given. I continue to assist the wife with how to communicate with the Palliative Team, and am guiding them both through the journey of anticipatory grief.



DONOR SUMMARY

April 1, 2021 – March 31, 2022

* Does not include donations to the Cyclepaths, which are tax receipted by Victoria Hospice. We apologize for any omissions on this list.

Champions \$125,000 - \$249,999

Estate of John Taylor Bowie

Believers \$50,000 - 124,999

Anonymous Estate

Builders \$15,000 - \$49,999

Garry Fizzell

Innovators \$5000 - \$14,999

Loren Barr
Violet Erskine
Linda Leslie
Marianne Muir
Estate of Georgena Langdon

Partners \$1000 - \$5000

Courtenay Return It Depot
Pacific Rim Storage Co.
Carol Baert
Richard and Maureen Swift
Brian McLean Chevrolet Buick GMC Ltd.
Philip Luke
M. Elaine Tulloch
Ken and Andrea Rowe
Keith and Sharon Ritter
Estate of Mary Bell
Cyrill Werlen

Advocates \$500 - \$999

Jayne Dyjur
Jane Sterk
Royal Canadian Legion #160
TD Canada Trust
Comox Return It Centre
Silvia Lyrenmann
Kathleen Woodley
John Wear
Comox Valley Monarch Lion Club
PayPal Giving Fund Canada
Christopher Swift
Robert Heron
Joan Udell
Provincial Employees Community Services Fund
Searle's Shoes Ltd.
Lana Veloso
Juanita Munroe
John Scrivin
Joan M. Hansen
Jim Argue
Jennifer Patriarche
Jacqui Graham
Darcy Germschied
CUPE Local 556
Craig Skene

Allies \$250 - \$499

Monique Thompson
Geek Tweaks Technology Solutions Inc.
The Benevity Community Impact Fund
(Joyce and John Kuhn)
Marion Bell
Norm Carruthers
St. Michael & All Angels Protestant Chapel
Ingrid Martin
Costco Wholesale Warehouse 1092
Bob and Alison Romanow
Barb Fehlau
Joan Gillies
Janet Haigh
Jon and Jill Ambler
Angela Hope
Uplifters Shop
Jean Gunderson
Gerry and Family Lainsbury
Chris and Margaret Hansen
Carol Kujala
Darcy Sauer
Robert and Myrna Trimmer
Nahanni Ackroyd
Judith Round
Judith Marriott
Jeffrey Reinhart
Comox Valley Duplicate Bridge Club

Grant Funders



Donors Summary Continued

April 1, 2021 – March 31, 2022

Supporters \$100 - \$249

Paula Horky
Doreen Blid
ABC Printing & Signs
Elisabeth Stubbs
John Kendall
Raymond and Laurie Harpell
Neil Ross
Ron Bowie
Joan Collinge
Beverley Worbets
Barbara Simonson
Elaine Kerr
Patricia Korven
Michelle Thompson
Lisa Jackson
Sharon Bearpark
Linda Davies
Ken Osmond
Bill and Judy Quigg
Valerie Taylor
Susan Pauwels
Susan Auchterlonie
Roslyn Smith
Ron and Beth Ritchie
Robert Allam
Peggy Rasmus
Leslie Giebelhaus
John Downing
Heather Pitman
Gerry & Val McClintock
Doreen Snelling
Dennis Enomoto
Deborah Nolan
Debbie Drake
Christopher Brocklebank
Barb Morris
Alison MacBeth
Wolfgang and Beverly Wolf
Wendy Smith
Terry and Jennifer MacLean
Suzanne Jensen
Stephen Richey
Brenda Davies
Blake Walton

Blaine Douglas
Beverly Brain
Barry and Mary Bowen
Anthony Farrell
Alyssa Bird
Shirley McCollister
Sheila Chadwick
Robyn Walsh
Robert Mortimer
Robert McDonald
Robert Chipperfield
Rick and Jan Brown
Raymond Hauser
Patricia Rowantree
Pamela J Reddy
Niels Holbek
Necia Kaechele
Natalie Anderson
Mike Van Holderbeke
Lori Walton
Ken Snyder
Keith Reid
Karen Robinson
Judy Waldrum
Judith Hagen
Josephina Jimenez
Jean Douglas
James Sharpe
Inge Stephenson
Heather Aitken
Hamish Murray
Gilbert Neufeld
Gerald Woloshyn
Eva Wilson
Donna McKinnon
Catherine Kilner
Maybeth Hoagland
Corrie Stoski
Bruce Bell
Michael Moravec
Tina Seigler
Len Lyle
Susan Hunter
Shirley Barr
Sandy Dreger
Sandra Johnstad
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SUPPLEMENTAL READING



Counsellor



BEHIND THE SCENES
A DAY IN THE LIFE OF
A CVHS COUNSELLOR

Submitted by Ruth Barry



A DAY IN THE LIFE OF A CVHS PALLIATIVE COUNSELLOR

By Ruth Barry - (Almost Retired)

* all names used are pseudonyms

At 6 am I awake, and spend 40 minutes of a meditative yoga to prepare me physically, emotionally, mentally and spiritually for my work. I will be meeting people in distress, so at least I should not be arriving with any issues to add to people's woes...

At 8 am, I check my CVHS in-box for information from admin and other CVHS clinical staff on clients, existing or new referrals who may be either in hospital or in need of my urgent attention. I also check my "fancy phone" - the invaluable Android business phone that keeps me connected with the other counsellors and our community partners.

Today I see a request to call Debra and her daughter Tara, both of whom wish to talk to me about Debra's anxiety and her fear of being admitted to hospital again if she collapses at home. Debra is 81 with a recently diagnosed rare disease that is palliative only if left untreated. She has refused any further treatments. There are complex family disagreements on her choices. I will call after Structured Team Report (known as STR) at the Comox Valley Hospital (CVH).

This Tuesday one of our new counsellors is also shadowing me. She meets me, as arranged, at the staff entrance at 8.20 am sharp. STR is on 3rd floor at 8.35 am.



Upstairs I check my Island Health email in case I have any confidential communication from the Island Health Palliative Care Team (including the Palliative Care Co-ordinators, the community palliative nurses, the Palliative Doctors, or other staff in the hospital who wish to alert me to any situations where Hospice support may be needed). I find an email from one of the Palliative Co-ordinators informing me that Irene is in Emerg distressed after a pain crisis at home. I had a scheduled home visit to see her and her husband this afternoon. She is apparently asking for me. STR begins.

Around the long table in the Nursing Station are the Clinical Nurse Leader (CNL), nurses for each unit who come and go to present the people for whom they are responsible that shift, physiotherapists, occupational therapists, a social worker, diet specialist, Home and Community Care Liaison, the occasional doctor with a specific piece of useful information, and Hospice. The intention of the daily meeting, which we attend twice a week, is to determine who is in hospital, what is the barrier to discharging them, what actions need to be taken to facilitate that process, and estimate a date of discharge.

We are listening for Palliative patients or their loved ones who may be in need of our services. STR takes place for units A and B, then across the hallway immediately afterwards for C and D with a different set of faces.

Mid-way through A/B I get a text from our Hospice at The Views (HaTV) Counsellor Angela to inform me that we currently have no empty beds at the Hospice, and that the current clients are unlikely to be departing any time soon. Helpful feedback in STR when there is pressure on bed move palliative folks out.



A DAY IN THE LIFE OF A CVHS PALLIATIVE COUNSELLOR

Submitted by Ruth Barry Continued...

Shortly after this, Henry, a 75-year old man with metastatic lung cancer is mentioned. The manager of flow for hospital beds is keen to get him out of hospital and back home or into Hospice. I am aware of Henry's situation and his wishes, and advocate strongly that he remain in hospital where he feels safe and his pain is controlled until his son arrives from Mexico. I also suggest a referral to the Hospice is appropriate. The nurse agrees to request this from the doctor immediately.

We identify seven Palliative people who should be visited and assessed for access to our services. Another four names are people I have already connected with the previous week, two of whom were open to regular visits by the hospital visiting volunteer team.

We note down three additional people who will be eligible in the near future – including a young man of 39 with a wife and two children under 10 who has just been told by his doctor that he has stage 4 pancreatic cancer. I will possibly see him tomorrow when he has had a chance to absorb the news. Going in too soon announcing one is from the Hospice Society tends to be ill-received! Timing is important...

STR is almost done when a nurse comes in flustered, having been refused entry by an angry family to William's room, a dying 91 year-old man. The Clinical Nurse Leader notes his palliative status. He mentions calling in the PSOs – i.e. Hospital Security. Several staff mention my name at the same time as I suggest that we first attempt a more peaceable intervention. They like this idea.

We make this a priority and head down the hall immediately. I pause to brief my new colleague – all we know are this man's name, age, diagnosis, and that his younger girl friend is accusing his son and daughter of elder abuse. Tensions are high and tempers have flared. William is distressed. This makes the situation my top priority today.

We can make no assumptions about anything. Creating a story around what we know is counter-productive and helps no one. We must enter the room, if we are allowed to do so, open-minded, compassionate, and calm.

I notice a young man and older woman striding down the corridor towards us. Intuitively, I know these are our people, and I can use this moment to advantage. I waylay them immediately, introducing ourselves as counsellors with the Hospice Society, and here to help resolve the stressful situation. I ask them to explain the circumstances that are causing them to look so distressed. Initial suspicion gives way almost immediately to relief and an outpouring of details. We talk outside the room awhile, and then go in together.

Twenty minutes later, all is calm in the room, and I leave the new counsellor to continue her positive connection with the emotional daughter while I use the excuse of showing another family member where to find warm blankets, to engage in a private conversation. I have identified him as the family peacekeeper, and our 10-minute talk ensures that he has the perspective he needs to keep the family positively focussed on William's dying needs.



A DAY IN THE LIFE OF A CVHS PALLIATIVE COUNSELLOR

Submitted by Ruth Barry Continued...

There are always different sides to every family story, and usually dramas and dynamics have been many years in the making. It is not our role to make assumptions or to cast judgement. And, we do not have all day to engage in depth psychotherapy...We head downstairs to Emerg.

We find Irene in a small windowless room at the back of Emerg – where our Palliative folks are almost always placed. It's quieter here, but dark and sometimes gloomy. Irene is alone and agitated – there is a panicked look in her eyes. She is extremely relieved to see a friendly face or two! We have never met, only spoken briefly on the phone to arrange that home visit which will now take place here.

I offer her my hand to give her an anchor point. She holds on firmly for the next half an hour. And she talks, and talks, and talks...

An enormous release of the tension of the past few days and weeks pours out – her initial feelings of horror at the myeloma diagnosis, her fears of not having enough time to complete important projects, her worry about her husband and his addiction issues, her gratitude at her circle of women friends who have come from across the world to see her and to help with both her practical and spiritual needs, her unrequited passion for a university lecturer, her certainty that she won't be going home again, and her thoughts about MAiD.

Irene is the most articulate and deeply appreciative person we will meet today. We leave with all of us feeling good. *(Footnote: Irene is admitted to 3rd floor and engages in long sessions with our new counsellors about her philosophy of life and her decision to have MAiD – which she happily does two weeks later in the hospital, surrounded by friends.)*

As we leave Irene's cubicle space, a nurse asks if we are here to see Grace, the 99-year-old grandmother of a staff member who has been diagnosed as “failure to thrive”, stops us! (You have to love that diagnosis...)

Apparently, the family expected Grace would be given a room upstairs but this has not happened and now she is dying in Emerg in a small windowless room. They are not happy.

"May we come in?" I ask, and immediately enter. A large family is gathered around the bed, all jammed into a space the size of a small bathroom. Grace is seemingly unaware, breathing noisily then stopping for long seconds, but not showing any signs of distress. The family is silent, anxiously watching and listening to her.

I notice and comment on the amount of love surrounding this lady. I suggest she must be someone special. I ask if they can share any stories that would tell us who she is. And they do...

It is a joyful experience, and there is laughter amid the tears. At some point, they notice that the room has ceased to matter, and that everything important is already present.

We leave after about 15 minutes, planning to return upstairs to 3rd floor, but are immediately beckoned by a Home and Community Care Liaison nurse. She is nervous about entering a room with an elderly lady, Elaine, aged 85, with advanced cancer, dementia and profound deafness. Not because of the patient, but her son, who has been in earlier and reduced the young and very kind nurse to tears with his aggressive manner, shouts, and demands for better care for his mother. She needs information to facilitate the woman's discharge home, but is unsure how the son will respond. He is due back any moment.



A DAY IN THE LIFE OF A CVHS PALLIATIVE COUNSELLOR

Submitted by Ruth Barry Continued...

We follow directions on the door to put on PPE, and go in. Elaine can hear nothing either of us say. I find a hearing-aide on the floor, which she puts in one ear. This helps a little but she is German and the dementia doesn't help. We understand that she wants to watch curling and doesn't know where the TV has gone.

Our new counsellor is shouting in her ear when the son arrives. He too is hard of hearing. I work hard to disarm him. After 10 minutes, I have succeeded in persuading him that taking his Mom home is his idea, a good one, and should be arranged forthwith. We leave both of them quiet and pleased, and give the Liaison the good news. She is mightily relieved!

There is no time now to return upstairs, and besides, we need a break. There is ALWAYS more need than we have the capacity to meet. We return to the CVHS offices where I make the phone call to Debra (and her daughter Tara) before planning to grab a 15-minute soup and coffee.

Debra is at home with her daughter and needs to talk. She is hard to understand – her disease makes her muddled at times, articulate at others, and her pain level is unmanageable using the methods she is willing to try. She sees a naturopath and does not have a family doctor. She tells me she has had enough and wants MAiD immediately.

I take the time to understand why she is asking this right now. It appears that two of her adult children have stopped talking to her because of her decision to refuse allopathic treatments that could maintain her life indefinitely.

It is clear that her physical symptoms worsen proportionately to her emotional and mental distress. At my request, she puts me on speakerphone so her daughter can hear my suggestions.

Despite my efforts, Debra insists again that she wants MAiD. I explain slowly and carefully how the process works. She needs to have the conversation with a medical professional. Her daughter suggests they make an appointment with her own doctor to talk it through and to my surprise Debra agrees. Knowing when to quit, I end the call with a promise to do a home visit session after her visit to the doctor. Tara will call me to arrange it.

At 2 pm the Clinical Team: Program Co-ordinator, Volunteer Co-ordinator, Program Assistant, and the Counsellors, meet for the next hour and a half to share relevant information on Anticipatory Grief, Bereavement, and Palliative Clients.

I share a brief synopsis of the morning in CVH, starting with the daily census number: 187 patients to 146 beds! (Yes, people are often in the corridors and in the sunrooms...) Hence the pressure from the hospital to discharge people fast, and hence the necessity for us often to advocate strongly to get our Hospice-ready clients appropriately referred and potentially admitted into the Hospice facility, or to advocate to keep them in hospital if that is the best direction for them and their families. The counsellor currently attending the Community Care Rounds gives a report on community palliative folks mentioned due to medical, mental, emotional or social complexities, or their family members identified as being in need of additional supports from our team. A report on those currently in the Hospice at The Views (HaTV) facility is given, and those on the referral list noted. The list of deaths, dates and places of death are recorded.



A DAY IN THE LIFE OF A CVHS PALLIATIVE COUNSELLOR

Submitted by Ruth Barry Continued...

I am able to share information today on two people currently on the HaTV referral list. As a result, Angela will advocate strongly for one of them at the HaTV Rounds tomorrow morning when decisions are made regarding priority for the next available bed.

The man in question is Dave, 58, living alone on the margins of society, with no family and only one friend locally who is exhausted and has been supporting him to the detriment of his own health. Dave is declining rapidly – he is terrified of hospitals and authority figures but has accepted the idea of a Hospice bed knowing that it is a comfortable un-pressured environment. He would like to write a final letter to an estranged sibling and knows he can get help from the volunteers in HaTV to do so. This would be a good admission.

The Program Assistant advises us on two new Palliative referrals that came in by fax this morning. One is from a doctor and is probably an inappropriate referral: the woman is not Palliative, nor bereaved, and sounds like she would better benefit from a Mental Health referral. I will make the call to the doctor after the meeting, ensure we have the information correct, and make a decision on our direction.

The meeting concludes and I call the second new referral, which is for a wife whose husband has been deemed palliative with liver disease and other co-morbidities for two years. She is exhausted and at breaking point. I have a telephone session with her to alleviate her immediate acute distress, and advise her to attend our drop-in Zoom Caregiver Circle on Friday at 2 pm. She feels heard, admits to feeling less alone after our talk, and agrees to join the circle on Friday. (Footnote: Her husband is admitted to hospital the next day and dies unexpectedly suddenly in Emerg before we can see either of them. I will call her later this week and she will be followed up by the Bereavement Counsellor when space and time allow.)

I spend the next half hour opening new files on clients, entering brief notes for those both new and existing whom we have seen or spoken to today, and noting those files to be closed and/or changed to Bereavement support. I get the new counsellor to practice doing some of them, so she can get the practice, and also so I can get home.

It is after 5 pm when I am done - in more ways than one! My husband asks me why I look so tired when he gets home shortly after me...

(Footnote: Please take good care of your CVHS counsellors - they do a lot more than you can imagine - and it takes every part of them to do this job with intelligence, compassion and integrity.



